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CONSULTATIVE EXAMINATIONS

guide for physicians

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CONSULTATIVE EXAMINATIONS

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guide for physicians

contents

	Page
Introduction	1
Type of Purchased Examinations and Selection of Source	2
Report Content and Signature Requirements for the Examining Physician	3
How the DDS Reviews Consultative Examination Reports	4
Essential Elements of Consultative Examination Reports	5
Internal Medicine (General)	5
Rheumatology	7
Respiratory	8
Cardiovascular	9
Orthopedic	10
Neurological	12
Mental Disorders	13

introduction

Frequently, in claims for social security or supplemental security income (SSI) disability benefits, the available medical evidence is not sufficient to make the disability decision. In such cases the Disability Determination Services (DDS) office requests the claimant to undergo a special consultative examination (CE) to get the needed medical information.

The examination fees are paid by the DDS with funds authorized by the Social Security Administration.

This guide tells about how the DDS's request CE's; what they look for in reviewing CE's; and the essential elements of CE reports for each of the seven most prevalent medical specialties involved.

type of purchased examination and selection of source

The type of examination and/or test(s) purchased depend upon the specific additional evidence needed for adjudication. If a laboratory test (e.g., X-ray, urinalysis, or EKG) will furnish the additional evidence needed for adjudication, the DDS will not authorize a more comprehensive medical examination.

The physician selected to do the examination or test must be competent to do so. While it is not required that the physician be a specialist in the medical field in which the examination or test is requested, the physician's qualifications must indicate that the physician is licensed and, in the judgment of the DDS, has the training and experience to perform the type of examination or test requested. In addition, the physician's professional conduct, reputation, and dealings in the community and with all government agencies must be such as to avoid an unfavorable reflection upon the government and erosion of public confidence in the administration of the program.

If the claimant objects to being examined by a designated physician and gives good reason for the objection, the DDS will attempt to comply and schedule an examination with another physician. A good reason might be where the CE physician had previously represented an interest adverse to the claimant. For example, the physician may have represented the claimant's employer in a worker's compensation case or may have been involved in an insurance claim or legal action adverse to the claimant. Other good reason examples are: language barrier, office location of CE physician (2nd floor, etc),) travel restrictions, and examination by the physician in connection with a previous unfavorable determination.

The attending physician can be an especially valuable source of purchased examinations. When the attending physician is qualified to perform the additional examination or tests and generally furnishes complete and timely reports, the DDS may select the attending physician to do the purchased examination. Even if only a supplemental test is required, the attending physician is ordinarily the preferred source.

report content and signature requirements for the examining physician

Report Content

The reported results of the history, examination, pertinent requested laboratory findings, discusssions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. Thus, the extent and detail of information expected in a report of general internal medicine examination will differ from that expected when a neurological, orthopedic, psychiatric, psychological, ophthalmological, otological or other examination is requested to address a specific issue. Moreover, the reporting of information will differ when the requested examination relates to the performance of tests such as ventilatory function, treadmill exercise or audiological tests. The medical report should be complete enough to enable a reviewing physician to determine independently the nature, severity, duration of the impairment and residual functional capacity. The history and physical examination must be provided as a narrative of the findings and not in the form of responses to a questionnaire or a check-off list. Pertinent points in the history, such as a description of chest pain, should report the individual's statement of the symptoms, not simply physician's statements of conclusions.

The examining physician's report of the consultative examination should include the actual medical facts as well as a statement (based on the physician's own findings) which should describe the individual's ability to do work-related activities, but not an opinion as to whether the claimant is disabled under the meaning of the law.

Signature Requirement

All consultative examination reports must be personally reviewed and signed by the physician who actually performed the examination. This attests to the fact that the physician doing the examination or testing is solely responsible for the report contents and for the conclusions, explanations or comments provided with respect to the history, examination and evaluation of laboratory tests results. The examining physician's signature on a report annotated "not proofed" or "dictated but not read" is not acceptable. ***The physician's rubber stamp signature or the physician's signature entered by another physician, or the physician's nurse, secretary or other person is not acceptable.***

how the DDS reviews consultative examination reports

The DDS has an obligation to see that the money expended for a consultative examination is prudently spent and that the report is obtained as quickly as possible. In discharging this responsibility, the DDS reviews the report of the consultative examination to determine whether the specific information ordered has been furnished.

The DDS considers the following elements:

1. Does the report provide evidence which serves as an adequate basis for decision-making in terms of the impairment it assesses?

2. Is the report internally consistent? Are all the diseases, impairments and complaints described in the history adequately assessed and reported in the physical findings? Do the conclusions correlate with the findings from the history, physical examination, and laboratory tests, and explain all abnormalities?

3. Is the report consistent with the other information available to the DDS within the specialty of the examination requested? Did the report fail to mention an impairment or relevant complaint within that specialty that is noted on other evidence in the file (e.g., the claimant's blindness in one eye, amputations, flail limbs, claw hands, etc.)?

4. Is this an adequate report of examination as compared to standards set out in the course of a medical education? This assessment is made by reviewing physicians based on their knowledge of writing reports. It is a somewhat subjective assessment of the character of the report.

5. Is the report properly signed?

If the report is inadequate or incomplete, the DDS contacts the physician, and asks that physician to furnish the missing information or prepare a revised report.

At the claimant's request or where the examination turns up diagnostic information or test results which would be of significance to the claimant's treatment, procedures call for the referral of consultative examination reports to attending physicians.

essential elements of consultative examination reports

Internal Medicine (General)

For reporting of a general internal medical examination, the following is expected:

- The detail and format for reporting the results of the history, physical examination, laboratory findings, and discussion of conclusions should follow the standard reporting principles for a complete and competent internal medical examination.

- The major or chief complaint(s) alleged as the reason for not working should be stated.

- Each major or chief complaint should be discussed in detail under the "History of Present Illness." The discussion of these complaints must present a detailed longitudinal description of the pertinent past history of the disease state in addition to the detailed description of the individual's statement of the current complaint. It is important to present, in as much detail as can be obtained from the individual, significant occurrences, including changes in the status of that complaint over time, hospitalizations with dates and names of hospitals, findings and treatment during the hospitalization as understood by the individual, and ongoing treatment. It is particularly important to provide a detailed description of the individual's current complaints, explaining those factors which increase the problem or impairment and those which may provide relief, and how the individual describes how the impairment limits the ability to function. Pertinent descriptive statements by the claimant, such as a description of chest pain, should be recorded in the claimant's words, to the extent possible. The information must be presented as a narrative description and not as the completion of a "questionnaire" or "check-off" form. Current medication should be listed by name of drug and dose.

- The "Past History" should describe other prior illnesses, injuries, operations, or hospitalizations and give the dates of these events.

- The "Review of Systems" should describe other complaints and symptoms the individual has experienced in the past relative to the specific organ systems as elicited in the system review. There should be a discussion of the pertinent negative findings which would be considered in making a differential diagnosis of the current illness or in evaluating the severity of the impairment.

- Pertinent findings under "Social" (e.g., use of tobacco products, alcohol, non-prescribed drugs) and "Family" history should be presented.

- The physician should indicate from whom the history was obtained and should provide an estimate of the reliability of the history.

- The vital signs should include the blood pressure, pulse rate, respiratory rate, and height and weight without shoes. The physical examination must provide a description of the individual's general appearance and pertinent actions during the examination (e.g., for an individual with a complaint of back or other musculosketetal disease, how the person stood or walked, got up from a chair and got on and off the examination table). This description must be presented as a narrative and not by annotation of a "check-off" form. Those aspects of the examination dealing with the individual's major and minor complaints should be presented in particular detail, describing pertinent negative findings as well as the positive findings. Pelvic examinations should not be performed unless specifically authorized by the DDS. Specific range of motion of a joint should be reported in degrees. This should be done for joints in which there is found a significant limitation of motion. If a joint is found to have no abnormality of range of motion on gross examination, that fact should be stated rather than reporting the degrees of motion.

- The actual reported values for laboratory tests must be given. The laboratory should provide the normal range of values for that laboratory for the tests which have been performed. This may be in the attached laboratory report instead of being in the body of the medical report. Electrocardiographic tracings and spirographic tracings must be provided when these tests have been performed. When ventilatory function tests have been performed, the reported findings must meet the requirements of section 3.00D of the Listing of Impairments. The interpretation of laboratory tests, such as electrocardiographic tracings, ventilatory function tests, and X-rays, must take into account and be correlated with the history and physical examination findings. If the formal reading or interpretation of the laboratory tests, electrocardiograms, X-rays, ventilatory function tests, etc., has been provided by a physician other than the physician signing the report, identificaiton of the physician providing the formal interpretation must be stated. If the interpretation is provided on a separate report sheet, that sheet should state the interpreting physician's name and address. The selection of joints to be X-rayed, as representative of those most involved by disease, is best determined on the basis of the results of the physician's examination.

- The physician obtaining the history and performing the physical examination must provide diagnostic and prognostic conclusions based on the clinical and laboratory findings.

- The physician signing the report must review the reported history and physical examination findings which must represent the information obtained by this physician in the examination of the individual. The conclusions provided by this physician must correlate with the findings from the history and physical examination, and laboratory tests obtained in conjunction with this examination. All abnormalities should be explained, or commented upon if a definitive explanation cannot be provided. This physician must also sign the report.

Rheumatology

In addition to the requirements for a general internal medical examination, the following specific information should be stated in a report of an examination in which the primary complaint is a rheumatological disorder.

Of great importance in the evaluation of claimants who allege joint or back problems as a reason for inability to work are the general observations by a competent observer with regard to stance, gait, ability to dress and undress, climb upon the examining table, grasp or shake hands, write, etc. Therefore, general observations in the physicial examination should relate to these common, everyday functions which may be observed in the examining physician's office.

Joint examination should include specific, detailed notations with respect to the presence or absence of effusion, periarticular swelling, tenderness, heat, redness, thickening of the joints, and specific range of motion of the joints and back in degrees.

The technique for measuring range of motion of joints and spine should be in accordance with the listing requirement in section 1.00 of the Listing of Impairments. If the range of motion is found to be restricted in any joint or spine, annotation should be made with regard to the probable cause of the restriction, whether primarily due to pain and/or influenced by observable abnormality.

Joint and spine X-rays should be performed in accordance with the results of a thorough musculoskeletal examination, on which basis selection of the appropriate X-rays would be made.

Respiratory

In addition to the requirements for a general internal medical examination, the specific information listed below should be stated in a report of an examination in which the primary complaint is a respiratory disorder.

Whether special tests are needed to evaluate the results of possible pulmonary function impairment depends on the results of a thorough history and physical examination, with particular reference to the cardiorespiratory systems on which basis a probable diagnosis of chronic respiratory disease may be made.

- Dyspnea should be described with respect to dates and mode of onset, seasonal influence, influence of infection and precipitating activities, whether it is associated with palpitations, wheezing, chest pain, or hyperventilation symptoms. Respiratory dyspnea should be differentiated from cardiac dyspnea.

- Particular inquiry should be made as to whether the claimant has a history of heart disease, has experienced paroxysmal nocturnal dyspnea or orthopnea, and whether there has been associated peripheral edema, hypertension, past myocardial infarction, angina, rheumatic heart disease, cardiac murmur, etc. Evaluation of episodic disorders, (e.g., asthma), requires details with regard to onset, frequency, duration of attacks, and mode of treatment.

- The employment history may be important in the evaluation of pneumoconiosis or exposure to physical irritants producing respiratory symptoms

- The general physical examination should particularly note the occurrence of cough, labored breathing, use of accessory muscles of respiration, audible wheezing, pallor, cyanosis, hoarseness, clubbing of fingers, or the presence of chest wall deformity. The diameter of the chest on inspiration and expiration should be noted. Distention of neck veins and ankle edema should be described if present. A specific annotation should be made as to whether the expiratory phase of respiration is prolonged. The breath sounds should be described. Diaphragmatic motion should be noted. The presence or absence of adventitious sounds on auscultation of the chest should be noted and described.

- Generally, a chest X-ray, hematocrit, and ECG provide useful additonal information to lead one to a diagnostic conclusion.

- Ventilatory function studies should be performed only if a chronic respiratory disorder affecting ventilatory function is suspected on the basis of the clinical data and ancillary information. If spirometry is performed, it should be done in accordance with the specifications in Section 3.00D of the Listings for evaluation of pulmonary insufficiency.

Cardiovascular

In addition to the requirements for a general internal medical examination, the following specific information should be stated in a report of an examination in which the primary complaint is a cardiovascular disorder.

Of particular importance in evaluation of ischemic heart disease is the history with respect to chest pain. Chest pain, if present, should be described in the claimant's own words with respect to mode of onset, character, location, radiation, frequency, duration, precipitating factors, and mode of relief. A longitudinal record of the character of the chest pain should be provided by the claimant to ascertain whether there is a predictable stable pattern of occurrence and whether there is evidence of a recent change in the pattern of the symptoms. It should be noted whether the pain also occurs at rest or awakens the individual from sleep or, in addition, whether it is related to ingestion of food or movement of the upper extremities.

Specific drugs used by the claimant currently and in the recent past for treatment of the cardiac disorder should be named, indicating the dosage and the response of the claimant's symptoms to these drugs. A statement should be made as to the usual duration of the symptoms, particularly of chest pain, and the time required to obtain relief on rest or after taking specific drugs such as nitroglycerin.

The examination findings must provide a detailed description of the examination of the heart, including comment on the heart sounds and rhythm, and must describe any jugular vein distention (including angle of reclining at which distention occurs), abnormal adventitious lung sounds, hepatomegaly, or peripheral edema of the extremities.

Where the primary issue is congestive heart failure, the history of heart disease must include discussion of the known factors in the development of the cardiac condition (e.g., myocardial infarction, rheumatic heart disease, value replacement, hypertension) and pertinent symptoms such as dyspnea, including level of exertion at which dyspnea occurs, orthopnea, paroxysmal nocturnal dyspnea, and peripheral edema. Participation in a cardiac rehabilitation program should be noted. The impact of the chest pain, dyspnea or other cardiac symptoms on daily activities should be specifically described.

Ancillary laboratory tests, e.g., ECG's at rest and/or exercise, should be reported in accordance with the Listing requirements. (The original or a legible copy of the ECG tracings *must* be supplied.) The reported X-ray findings should provide a basis for evaluating any abnormalities against the requirements stated in Listing 4.02.

Orthopedic

For reporting of an orthopedic examination (including the lumbar and cervical spine), the following is expected:

- The major or chief complaint(s) alleged as the reason for not working should be stated.

- Each major or chief complaint should be discussed in detail under the "History of Present Illness." The discussion of the complaints must present a detailed longitudinal description of the pertinent past history of the disease state in addition to the detailed description of the claimant's statement of current complaint. Current and pertinent past therapy for this disorder, and response to therapy, should be reported. Hospitalizations, surgical operations, and significant investigative procedures (e.g., myelography, CAT scan) should be reported giving the dates of the hospitalization and result of the procedure in as much detail as the claimant can provide.

- Of particular importance in reporting the history is a detailed description of the symptoms alleged, including a description of the character, location, and radiation of pain; mechanical factors which incite and relieve the pain; prescribed treatment, including name, dose, and frequency of any analgesics which are used; and a description of the claimant's typical daily activities. Any symptoms of weakness, other motor loss, or any sensory abnormalities must be described in detail.

- Any evidence/history of abuse of drugs or alcohol should be included in the report.

- The past history should discuss other significant past illnesses, injuries, or operations, particularly those involving the musculoskeletal system.

- The physical examination should provide a statement concerning the claimant's general appearance and nutrition, and any apparent skeletal or other musculoskeletal abnormalities, in addition to the blood pressure, pulse rate, height, and weight.

- The gait and station must be described in detail and examples provided of the claimant's ability to tandem walk, walk on heels and toes, hop, bend, squat, arise from squatting position, dress and undress, get up from a chair, get on the examining table, and generally cooperate during the examination. If the claimant uses a crutch or cane, describe the claimant's ability (or inability) to ambulate without the device.

- There must be a detailed description of the orthopedic and neurological examination findings. These should include a description of limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, and deep tendon reflexes. Motor function should be quantitated and the method of quantitation reported. For example, if a numbering system is used, the report must state which number represents normal strength and which represents total paralysis. The report should also describe to what degree motor function is inhibited by spasticity, rigidity, or pain. When sensory deficit or pain is reported, the specific distribution of these findings must be described. Deep tendon reflexes should be described as to intensity and symmetry.

- Muscle bulk should be described, and when there is asymmetry, specific measurements must be reported. Atrophy must be reported in terms of circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of atrophy of hand muscles may be given without measurements of atrophy, but should include measurements of grip strength.

- The physical examination findings must be determined on the basis of the physician's observations during the examination and not simply a report of the claimant's allegations, e.g., the claimant says the left leg is weak, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, when possible, e.g., a seated straight-leg raising test in addition to a supine straight-leg raising test.

- When X-rays or other specific laboratory tests have been performed, the physician providing the formal interpretation must be identified. If the interpretation is provided on a separate report form, that report should be attached and show the interpreting physician's name and address.

- The physician signing the report must review the reported history and physical examination findings which represent the information obtained by this physician in the examination of the individual. The conclusions provided by this physician must correlate with the findings from the history and physical examination, and laboratory tests obtained in conjunction with this examination. All abnormalities should be explained, or commented upon if a definitive explanation cannot be provided. The physician must also sign the report.

Neurological

For reporting of a neurological examination, the following is expected:

- The major or chief complaint(s) alleged as the reason for not working should be stated.

- Each chief complaint should be discussed in detail under the "History of Present Illness." The discussion of these complaints must present a detailed longitudinal description of the pertinent past history of the disease state in addition to the detailed description of the individual's statement of current complaint. The mental or physical functional restrictions should be described with citations of specific examples. Current and past therapy for the disorder alleged should be reported and any abuse of drugs or alcohol should be discussed.

- The past history should discuss significant illness, injuries, or operations, particularly those involving the nervous system.

- The family history should provide information on pertinent positive abnormalities, particularly those involving hereditary familial conditions.

- The physical examination should provide a statement concerning the claimant's general appearance, nutrition, body type (build), head size and shape, and any skeletal or other abnormalities such as pigmentary or texture changes of the skin or changes in hair distribution. "Handedness" should be reported in addition to blood pressure, pulse rate, respiratory rate, height, and weight.

- A mental status examination should always be reported, but should be more extensive when mental capacity is in question. The physician should provide examples of responses in testing orientation, memory, calculation, insight, general understanding, and fund of knowledge. Mood and behavior during the examination should be noted, and any significant abnormalities should be described.

- Any impairment of speech should be described in detail with a statement as to how much ability the claimant retains and how the physician determined this. Aphasia, dysarthria, stuttering, and involuntary vocalizations must be noted and comments made as to whether speech is intelligible and fluent.

- The gait and station must be described in detail and examples provided as to the claimant's ability to tandem walk, walk on heels and toes, hop, dress and undress, get up from a chair, get on the examining table, and generally cooperate during the examination.

- Some notation should be made of the function of the 12 cranial nerves (if the first cranial nerve is not tested, as is frequently the case this should be noted.) Ocular motility and pupillary size and activity should be described even when normal. The visual acuity and visual fields by gross confrontation should be estimated, and the basis for the estimate must be stated. Examination of the lower cranial nerves should be described in particular detail when dysphagia or dysarthria is a prominent complaint.

- Motor function should be quantitated, and the method of quantitation reported. For example, if a numbering system is used, the report must state which number represents normal strength and which represents total paralysis. The report must also describe to what degree motor function is inhibited by spasticity, rigidity, involuntary movement, or tremor. Muscle bulk should be described, and when there is asymmetry, measurements should be reported. Atrophy, fasciculations, myotonia, and myoclonus should be noted when present. The degree of fatigability following rapid, repetitive movements should be noted.

- All modalities of sensation, including cortical, should be tested. The method of testing should be recorded. When sensory deficit or pain is described in a specific distribution, care should be taken to ascertain that the findings are consistent with neuroanatomical fact. Suspected nonphysiological observations should be noted.

- Coordination should be tested and the ability to perform fine and dexterous movement of the hands should especially be described. Any incoordination or tremor resulting at rest or during specific tests should be described in detail and quantitated. Examples should be given describing the functional loss which occurs because of these events.

- Deep tendon reflexes should be described as to intensity and symmetry. Superficial reflexes should be described when present and noted when absent. Any pathological reflexes must be described in detail.

- The physician signing the report must review the reported history and physical examination findings which must represent the information obtained by this physician in the examination of the individual. The conclusions provided by this physician must correlate with the findings from the history and physical examination, and laboratory tests obtained in conjunction with this examination. All abnormalities should be explained, or commented upon if a definitive explantion cannot be provided. The physician must also sign the report.

MENTAL DISORDERS

The report of the psychiatric or psychological examination should show the effect of the emotional or mental disorder on the claimant's ability to function at the usual and customary level of adjustment—personal, social and occupational. The report should include:

General Observations:

- How the claimant came to the examination (alone or accompanied; distance and mode of transportation; if by automobile, who drove).
- General appearance: Dress, grooming, appearance of invalidism.
- Attitude and degree of cooperation.
- Posture and gait.
- Involuntary movements.

History: The psychiatrist or psychologist should indicate from whom the history was obtained and should provide an estimate of the reliability of the history.

Present illness: The history must provide a detailed longitudinal description of the pertinent past history of the disease state in addition to the detailed description of the individual's statement of the current complaint.

- Date of onset, including when the claimant became unable to work and whether an attempt was made to resume work.
- Claimant's complaints and how the impairment limits daily activities.
- Claimant's daily activities, interests, and habits (specify informant).
- Hospitalizations—if for treatment of mental disorders, state where, dates of hospitalizations and duration, condition on admission, therapy, condition on discharge.
- Other treating sources—if for treatment of mental disorders, state name of source, date of treatment and duration, condition when first seen, therapy, condition when last seen.
- Therapy—type of therapy and response. If medications have been used state drugs by name and dose if known, and results achieved.

History of other pertinent medical events.

Personal and family history: include a longitudinal biographical profile of the claimant's relevant educational, social, military, marital, and occupational adjustments in terms of ability to conform to social standards, to hold employment and advance in career, and to adjust to superiors and fellow workers.

Mental Status – Detailed description of:

- Claimant's attitude and behavior.
- Stream of conversation and psychomotor activity. (Provide examples.)
- Mood, affective status, and emotional reactions.
- Content of special preoccupations (provide verbatim samples).
- Sensorium (orientation), memory, and intellectual resources (provide examples).

Required Additional Information by Type of Disorder:

Psychotic reactions (both organic and functional): In addition to a detailed description of clinical observations and findings, the report should reflect:

- Social, personal, and occupational regression as evidenced by restriction of daily activities, constriction of interests, and impaired ability to relate to other people.
- Whether the duration of the psychotic reaction is expected to last for at least 12 months.
- Frequency and duration of individual episodes and quality and duration of any intervening periods of remission.
- Inpatient and outpatient treatment and response (if not previously described).

Functional nonpsychotic disorders (psychophysiologic, neurotic, and personality disorders; addictive dependence on alcohol or drugs):

- Social, personal, and occupational limitation as evidenced by restriction of daily activities, constriction of interests, deterioration in personal habits, and impaired ability to relate to other people.
- Description of manifestations of tension, anxiety, depression, hysterical reactions, obsessive-compulsive patterns, psychophysiological disturbances, or substance use disorders.
- Evidence of trophic changes resulting from chronic disuse of muscle groups, e.g., as in conversion reactions.

Organic brain syndromes:

The documentation of intellectual deterioration requires the clinical description of affect, intellect, judgment, orientation, and memory.

Mental Retardation:

Required psychometric documentation:

- Current documentation of IQ by a standardized, well-recognized measure. Acceptable instruments will have a representative normative sample, a mean of approximately 100 and standard deviation of approximately 15 in the general population, and cover a broad range of cognitive and perceptual-motor functions (e.g., the Wechsler scales).

- Individual subtest scores, where appropriate, along with numerical IQ and interpretations.

Assessment of the validity of the obtained IQ as well as a description of the claimant's attitude and degree of cooperation during evaluation; also, any circumstances that might have affected test findings (e.g., visual and physical impairments; recent prior exposure to the test).

Degree of claimant's current and predicted self-sufficiency in terms of personal, social, and occupations competence.

Diagnosis:

- Current APA standard nomenclature.

Prognosis:

- Probable duration and expected results of any recommended treatment.

The examining psychiatrist's or psychologist's opinion of the claimant's ability to manage own benefits.

The psychiatrist or psychologist signing the report must review the reported findings which must represent the information obtained in the examination of the individual. The conclusions provided by this psychiatrist or psychologist must correlate the findings. All abnormalities should be explained, or commented upon if a definitive explanation cannot be provided. This psychiatrist or psychologist must sign the report.

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